Department of HUMAN SERVICES

Health Home Learning Collaborative

Transitional Care

February 2022

This Training is a Collaborative Effort Between the Managed Care Organizations and Iowa Medicaid Enterprise

Iowa Medicaid Enterprise
Pamela Lester
plester@dhs.state.ia.us
LeAnn Moskowitz
lmoskow@dhs.state.ia.us
Heidi Weaver
hweaver@dhs.state.ia.us

Iowa Total Care
Bill Ocker
Bill.J.Ocker@IowaTotalCare.com
Tori Reicherts
Tori.Reicherts@IowaTotalCare.com

Amerigroup
Sara Hackbart
sara.hackbart@amerigroup.com
David Klinkenborg
david.klinkenborg@amerigroup.com
Katie Sargent
katie.sargent@amerigroup.com

AGENDA

1. Introductions
2. Transitional Care……..…….Martha Boese AGP
3. Health Home Case Study/Health Home Spotlight…… Lisa Babcook & Brenda Keller/CHCSEI
4. Questions/Open Discussion……..…All

Coming up (Subject to change):

- *March 21, 2022: Care Coordination: Understanding Long-term Care Services, Medicaid Programs, Mental Health & Disability Service Regions, & Court-ordered Services*

Learning Objectives

- Transition types
  - Hospital Admissions
  - Home vs. other settings
  - Reasons for transition
  - Health Home responses
- Discharge planning
  - Hospital discharge planning
- Lisa Babcook & Brenda Keller
  - Community Health Centers of Southeast Iowa

TYPES OF TRANSITIONS

Hospital Admission

- If Member was in Community:
  - Inform Providers
  - Complete CIR
  - Discuss discharge plan

- If Member was in a Nursing Facility:
  - Contact MCO CBCM
  - Determine the bed level

Transitioning & the Health Plan

Returning Home vs. Transitioning into Facility Living

Home to:
- Hospital
- Facility (NF, SNF, RCF, LTC, etc.

Hospital to:
- Home
- Facility

Nursing Facility to:
- Home

Facility to:
- Facility
- Home

Other reasons for transitions & health home responses

WHY TRANSITION?

- Facility ≠ Member needs
- Member ≠ care for self ≠ inadequate support in home
- Member individual desires aspirations for independence

HEALTH HOME RESPONSIBILITY

- Support Member during transition
- Work with Member and support system

GOALS OF TRANSITION

Help member obtain living environment that is the:

- Most integrated
- Least restrictive
- Safest

Help Member:

- Work directly with Member
- Instill confidence in Member
- Support Member

DISCHARGE PLANNING

Hospital Discharge Planning

- Review member needs
- Where is member going?
- What support or resources are needed?

Hospital Discharge Planning

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- Work with member's support
- Coordinate and establish new services
- Contact providers to initiate services

Hospital Discharge Planning

- Review member needs
- Where is member going?
- What support or resources are needed?

- Work with member's support
- Coordinate and establish new services
- Contact providers to initiate services

- Member is discharged
- Follow-up with member

Department of
HUMAN SERVICES

Lisa Babcook & Brenda Keller Community Health Centers Southeastern Iowa, Inc.

CHC
COMMUNITY
HEALTH CENTERS
OF SOUTHEASTERN IOWA, INC.

Health Resources and Services Administration
HRSA
Health Center Program
HEALTH CENTER
QUALITY LEADER
2021
Awardee

iowahealth+

Hypertension Control Champion
2019

Your health home

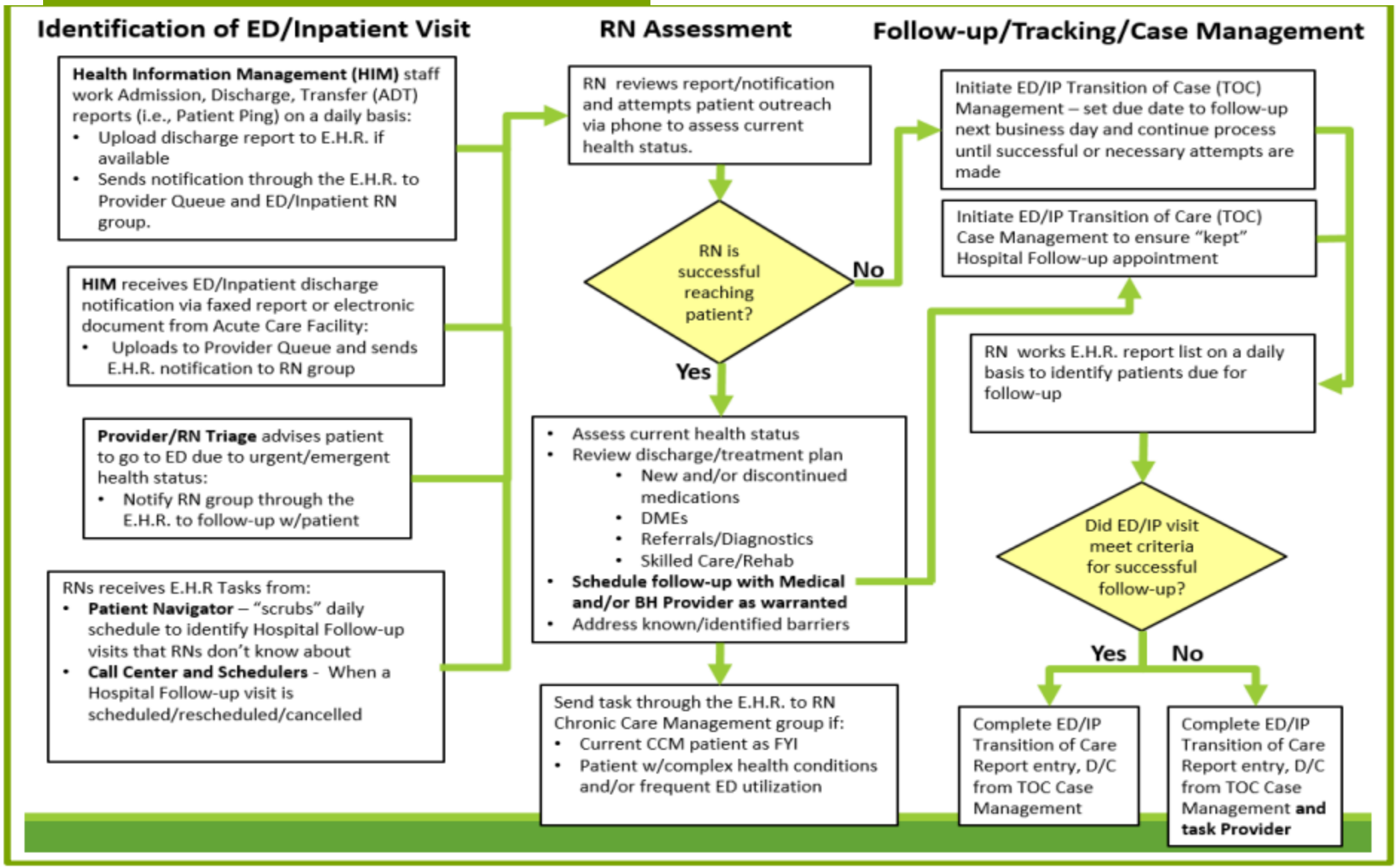
PCMH

Health Resources and Services Administration
HRSA
Health Center Program
NATIONAL QUALITY
LEADER
2020
HEART HEALTH

CHC/SEIA Provided Services to 22,595 distinct patients in 2021

- 2 RN Care Managers: Hospital and ED Follow-Up
  - Managing approximately 600-800 ED/Inpatient Visits per month
- 5 RN Patient Care Managers: serving 5 clinical sites
  - RN Care Management services provided to approximately 450 patients (200 CCHH members)

Hospital Follow-up Processes



Impacting our members

Stories of improving and helping our members during and after transitions of care

CHC/SEIA Hospital Follow – Up Quality Reporting

GOAL: 80% of visit meet numerator criteria

ED Measure Numerator:	Patients who completed a follow-up ED visit phone call with SEIA RN staff OR who completed a follow-up with PCP within 7 days of ED visit
ED Measure Denominator:	Patients who have been identified to have had an ED visit during the reporting month and primary reason for ED visit was not a behavioral health diagnosis
Measure exclusions	ED visits that resulted in IP or Observation status are excluded from this measure New patients who present at first office visit for ED follow-up are excluded
IP Measure Numerator:	Patients who completed a follow-up IP/Observation visit with their PCP within 7 days of IP or Observation discharge.
IP Measure Denominator:	Patients who have been identified to have had an IP or Observation hospital stay during the reporting month
Measure exclusions	New patients who present at first office visit for IP/Observation follow-up are excluded from this measure
Behavioral Health ED Numerator	Patients who completed a follow-up ED visit phone call with SEIA RN staff or who completed a follow-up with PCP or behavioral health provider within 7 days of ED visit
Behavioral Health ED Denominator	Patients who have been identified to have had an ED visit during the reporting month and primary reason for ED visit was a behavioral health diagnosis
Behavioral Health Exclusions	ED visits that resulted in IP or Observation status are excluded from this measure New patients who present at first office visit for ED follow-up are excluded
Behavioral Health IP Numerator:	Patients who completed a follow-up IP/Observation visit with their PCP within 7 days of IP or Observation discharge.
Behavioral Health IP Denominator:	Patients who have been identified to have had an IP or Observation hospital stay during the reporting month
Measure exclusions	New patients who present at first office visit for IP/Observation follow-up are excluded from this measure

CHC/SEIA Hospital Follow-Up Quality Reporting

CHALLENGES	IN PROGRESS

➢ Large volume of ED/Inpatient visits
  ➢ Averaging 600 – 800 visits monthly
➢ Untimely notification of ED/Inpatient discharge
➢ Staffing levels
➢ Follow – up appointment access
  ▪ Provider schedules are full
	➢ Proposal to Board for additional 1.0 FTE Hospital Follow – up RN Care manager
	➢ Improve health information exchange (HIE) networks and increase access to area hospital EHR systems
	➢ Develop hospital follow – up process for new patients
	➢ Monthly ED/Inpatient peer review
	➢ RN training/re-training on Motivational Interviewing (MI) techniques
	  ▪ ICCC Clinical Health Coach

PEER TO PEER SHARING

What transitions activities does your organization use that work well?

What are your biggest challenges?

How do others deal with these challenges and/or have successfully overcome these barriers?

Questions?

Thank you!